Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

Testimony of Victoria Veltri
State Healthcare Advocate
Before the Human Services Committee
In support of HB 5450
March 13, 2012

Good afternoon, Representative Tercyak, Senator Musto, Senator Markley, Representative Gibbons, and members of the Human Services Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

House Bill 5450, an act establishing a Basic Health Program (BHP), represents an important step in the movement towards equitable access to affordable and quality healthcare for all of our citizens. For Connecticut to be competitive, our people must be healthy. Under the Patient Protection and Affordable Care Act (PPACA), states have the option to develop and implement a BHP for individuals with incomes between 133 and 200% of the federal poverty level (FPL), funded almost entirely with federal dollarsWithout a BHP, individuals in this income range are at significant risk to have

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the benefits of PPACA go unrealized, as expected premiums in the Exchange are potentially cost prohibitive. While it is ideal to have as many lives in the Exchange as possible, expected premiums in the Exchange are potentially cost prohibitive for an estimated 77,000 people between 133% and 200% of FPL. If we do not establish a BHP, these people will remain either un- or under-insured. When they access care, it will likely be in a more costly setting and uncompensated, shifting the financial burden onto providers and, through cost-shifting, the rest of us as well. This is a scenario we can and must avoid.

The Mercer study notes that of an estimated 77,000 people eligible for a BHP, up to 50% of those eligible would not enroll in an Exchange due to out of pocket costs. For a single person with income at 138% FPL, these annual costs can range from $1,233, or 8% of total income, assuming minimal use of the healthcare system, to $2,004, or 13% of income, for high utilization. For a family of four living at 200% FPL, this factor can reach as high as $5993, or 13% of income.

The implementation of a BHP addresses this concern by providing to affordable healthcare, with a robust benefit design that mirrors Medicaid, while remaining cost neutral to the state. HB 5450 makes this possible by requiring that the BHP be designed to operate within the federal subsidies provided by PPACA, which will give states 95% of the expected premium for the selected benchmark plan and 95-100% of the cost-sharing subsidies. In addition, HB 5450 shifts HUSKY parents into the BHP, resulting in an increase in federal subsidies from 50% for HUSKY to 95% for the BHP, with estimated savings to the state of nearly $50 million. These savings must be utilized to increase provider compensation rates, as well as equalize benefits of the BHP with those provided by Medicaid.

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One issue surrounding the implementation of the Exchange concerns "churning", the movement of people in and out of plans as their income fluctuates. While this issue cannot be eliminated, the implementation of a BHP will significantly reduce its impact on plans by raising the Exchange eligibility from 133% to 200% FPL. There will inevitably be churning at this level, but far less than is predicted at 133% FPL. In addition, by having the BHP mirror Medicaid, the financial and practical impact of such movement across plans can be mitigated, as the systems and administration may be shared, creating a seamless transition for members and reducing administrative overhead and complexity. Another advantage of using this model is that the Behavioral Health Partnership has a far more vigorous benefit design, something that this population needs and mental health parity requires.

The creation of a BHP will substantially reduce the cost of insuring this vulnerable, low income population, increasing their access, sustainability and overall health. At the same time, we avoid jeopardizing the long-term viability of and higher premiums in the Exchange by including this traditionally higher morbidity population in the risk pool. This is the right opportunity and the right time to seize it, from both a public health and fiscal policy perspective.

Thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.

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